

**DOCUMENT 1  
HEALTH PROVIDER NETWORK  
PARTICIPANT ORGANIZATION  
SECURITY AND USE POLICY**

## **I. Introduction**

The New York State Department of Health (NYSDOH) has developed the Health Provider Network (HPN) as a secure system for electronically collecting and distributing health related data. NYSDOH uses techniques, which ensure that data exchanges between the HPN and providers are done in a secure fashion and also provide security for data on the HPN.

This document highlights security terms, conditions and responsibilities that Participant Organizations must agree to in the handling of sensitive data accessed using the HPN.

## **II. Overall Security**

Participant Organizations are responsible for the security of data physically located on, or transported over their network. This includes validation of users accessing the network; physical security of computers on their network; security of removable data; and immediate notification of the NYSDOH when status of the authorized individual user changes, due to reassignment of duties, or change of employment. The number to call to immediately notify the NYSDOH is 1-866-529-1890.

## **III. Data Disclosure**

Employees or agents of the Participant Organizations who have obtained information from the HPN shall not disclose this information to any other person unless that person is authorized and has official reason to see that information.

## **IV. Responsibility**

The Participant Organization assumes the responsibility for the actions of its employees or agents. The Participant Organization's employees or agents requiring access to the HPN will be given an HPN Individual User Security and Use Policy and Application. The Participant Organization agrees to the terms of the Individual User Security and Use Policy and Application. The Participant Organization agrees to notify NYSDOH within three business days of when it knows that the HPN access status of the Individual User is to change, e.g. due to change of work responsibility, or change of employment. The number to call to notify NYSDOH is 1-866-529-1890.

## **V. HPN Coordinator**

Participant Organizations are required to designate a person to serve as HPN services Coordinator. This means filing section IX of Document 1, and Document 2. The HPN Coordinator will be the principal point of contact concerning HPN access. **The Participant Organization will notify the NYSDOH if a new Coordinator is appointed by submitting a new section IX of Document 1 to name another Coordinator for the Organization.**

Every HPN Coordinator needs to have an active HPN account, which means filing a Document 2 with the Document 1 for the Organization. The Coordinator will keep NYSDOH apprised of issues and problems, and will also advise NYSDOH of changes that would affect the HPN connection or security by calling 1-866-529-1890. This includes advising NYSDOH within three days of when the Individual User is to change, e.g., due to change in responsibilities or employment. The Coordinator will use the HPN Coordinator page on the E-Commerce site to get the most current HPN account forms (Document 2), find out where to send completed forms, and maintain a current list of valid users for the organization.

In the event that an HPN Coordinator is not fulfilling the HPN Coordinator responsibilities, e.g. unresponsive to inquiries from NYSDOH, NYSDOH may direct the Participant Organization to appoint a replacement.

## **VI. Investigations**

The Participant Organization will notify NYSDOH of any actual or suspected violations of this policy and will cooperate with NYSDOH in any subsequent investigations. Detailed logging of all HPN communications activity may be required during the course of an investigation.

## **VII. Revocation of Access**

Access to the HPN is a privilege, which will be revoked if violation of HPN security policies occur.

**VIII. New York State Department of Health  
HPN Document 1 - Establishing an Organization HPN Account**

I have read and understand the Participant Organization and Use Policy and the attached HPN Individual User Security and Use Policy and Application. I, having authority to bind the Participant Organization identified below to these terms and conditions, agree to such terms and conditions as set forth in this document.

Name of Participant Organization: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Name of Signer (Print): \_\_\_\_\_ (Title) \_\_\_\_\_

Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_ Fax: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

State of New York ) ss.:  
County of \_\_\_\_\_)

On the \_\_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_ before me, the undersigned, personally appeared \_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory evidence, to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and by his/her signature on the instrument the individual executed the instrument.

Notary Signature on this line:

\_\_\_\_\_  
NOTARY SIGNATURE AND STAMP

DOH CAM or program contact to receive form: \_\_\_\_\_

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**NEW YORK DEPARTMENT OF HEALTH USE ONLY**      Program Completes the Following:

**PARTICIPANT TYPE** \_\_\_\_\_ **IDENTIFYING #** \_\_\_\_\_

The \_\_\_\_\_ has satisfactorily reviewed the Organization HPN Security and Use Policy  
(CAM or Program Area)

and confirms that the organization above has legitimate reason to access the HPN. Should the HPN **user status** of the Coordinator **change**, the Program agrees to notify the Bureau of Health Network Systems Management - Production Control Unit (BHNSM-PCU) immediately at **518 474 7835**. The original document has been maintained and we have provided the BHNSM-PCU with two copies of complete forms.

\_\_\_\_\_  
(Sign)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Title)

**Production Control Completes the Following:**

HPN ID \_\_\_\_\_ DATE Created \_\_\_\_\_ INIT \_\_\_\_\_

**IX. New York State Department of Health  
Designating New or additional HPN Coordinators/Changing Existing Coordinators**

I have read and understand the Participant Organization and Use Policy and the attached HPN Individual User Security and Use Policy and Application. I, having authority to bind the Participant Organization identified below to these terms and conditions, agree to such terms and conditions as set forth in this document. I have designated the following individual:

\_\_\_\_\_ as HPN Coordinator

HPN User ID (if one exists) \_\_\_\_\_ - (If not, this document must be accompanied by a Document Two for this individual.)

**If this person is replacing an existing HPN Coordinator, please check here** \_\_\_\_\_

Name of HPN Coordinator being replaced: \_\_\_\_\_ HPN/HIN ID \_\_\_\_\_

\_\_\_\_\_ Check here if this person needs to retain HPN access though no longer an HPN Coordinator.

Name of Participant Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Organization Signer (Print): \_\_\_\_\_ (Title) \_\_\_\_\_

Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_ Fax: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

New HPN Coordinator accepts the responsibilities identified above:

HPN Coordinator signature: \_\_\_\_\_ Date \_\_\_\_\_

Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_ Fax: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_

State of New York \_\_\_\_\_ ) ss.:

County of \_\_\_\_\_ )

On the \_\_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_ before me, the undersigned, personally appeared \_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory evidence, to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and by his/her signature on the instrument the individual executed the instrument.

Notary Signature on this line:

\_\_\_\_\_  
NOTARY SIGNATURE AND STAMP

**DOH CAM or program contact to receive form:** \_\_\_\_\_

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**NYS DEPARTMENT OF HEALTH USE ONLY (CAM or Program Completes the Following):**

**PARTICIPANT TYPE** \_\_\_\_\_ **IDENTIFYING #** \_\_\_\_\_

The \_\_\_\_\_ has satisfactorily reviewed the Organization HPN Security and Use Policy  
(CAM or Program Area)

and confirms that the organization above has legitimate reason to access the HPN. Should the HPN **user status** of the Coordinator **change** the Program agrees to notify the Bureau of Health Network Systems Management Production Control Unit (BHNSM-PCU) immediately at **518 474 7835**. The original document has been maintained and we have provided the BHNSM-PCU with two copies of complete forms.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Title)

**Production Control Completes the Following (where applicable):**

HPN ID \_\_\_\_\_ PIN DATE \_\_\_\_\_ IPW DATE \_\_\_\_\_ INIT \_\_\_\_\_

HPN—11/01/2001